Honoring Choices®
PACIFIC NORTHWEST

AN INITIATIVE OF

Washington State Hospital Association

Washington State Medical Association

Jessica Martinson, MS

Director, Clinical Education and Professional Development

Washington State Medical Association

Lead Faculty, Honoring Choices Pacific Northwest


We are largely unprepared
for something totally predictable

Why Advance Care Planning?

90%	People say that talking with their loved ones about end-of-life care is important
27%	Have actually done this
82%	People say it's important to put their wishes in writing
23%	Have actually done this
70%	People prefer to die at home
70%	People die in a long-term care facility or a hospital
8.8x	Increased likelihood of prolonged grief if loved one dies in ICU vs. home with hospice
5x	Increased likelihood of PTSD if loved one dies in ICU vs. home with hospice
10 days	Fewer days spent in hospital during last two years if patient participated in advance care planning

Honoring Choices® Pacific Northwest

Vision

Everyone in Washington will receive care that honors personal values and goals at the end of life.

Honoring Choices® Pacific Northwest

An initiative to inspire conversations about the care people want at the end of life.

Public

Make informed choices about end-of-life care.

Health care organizations and community groups

Discuss, record and honor end-of-life choices.

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AN INITIATIVE OF Washington State Hospital Association | WSMA Washington State Medical Association

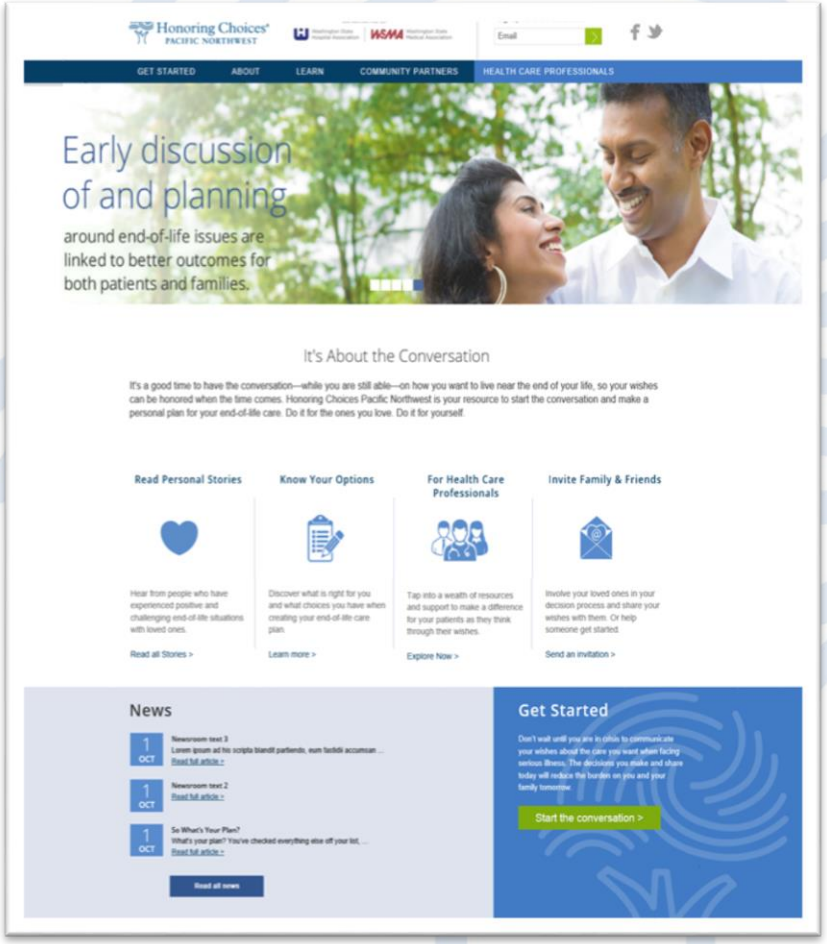
Website: HonoringChoicesPNW.org

Resources for the Public

- Start the Conversation
- Make a Plan
- Personal Stories
- Invite Family and Friends

Resources for Professionals

- Research, Articles
- Conferences, Trainings



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Advance Care Planning Program Guiding Principles

- **Upstream** – conduct advance care planning with healthy adults, before an illness or a crisis
- **Culturally sensitive** – adaptable to diverse communities
- **Sustainable** – lasting infrastructure sustains initiative after roll-out
- **Community based** – empower community to create culture change
- **Alignment** – support and learn from what works well in Washington
- **Standardization** – use evidence-based practices to standardize processes, while allowing for rapid cycle improvement
- **Results oriented** – meaningful measures to demonstrate progress

Advance Care Planning Program

- Gundersen model
  - Internationally recognized evidence-based program
- Advance Care Planning should be:
  - an ongoing process of communication
  - integrated into routine, patient-centered, preventive care
  - systemically supported by workflows, trained professionals, EMRs and communities

Respecting Choices®

ADVANCE CARE PLANNING

The Respecting Choices ACP System

***All slides used with permission of Respecting Choices.**

RC 0722_LE_OverviewWeb_v10.15 | Developed in collaboration with Honoring Choices® Pacific Northwest

The Desired Outcome of Advance Care Planning (ACP) is

To know and honor an individual's informed plans by

- Creating an effective planning process, including
  - Selecting a well-prepared healthcare agent or proxy, when possible
  - Creating specific instructions that reflect informed decisions geared to the person's state of health
- Making plans available to treating health professionals
- Assuring plans are incorporated into medical decisions, when needed

Advance Care Planning vs. Advance Directive

Bree's Definition of Advance Directive

A written instruction relating to the provision of future health care for a time when an individual is incapacitated.

The term "Advance Directive" refers to a collection of three documents:

- durable power of attorney for health care form
- living will or health care directive
- written personal statement about health care values and goals

Other documents can also be included under the umbrella term "advance directive" at an individual's discretion, such as other forms (e.g., Five Wishes) or instructions for organ donation.

Physician Orders for Life Sustaining Treatment (POLST) are not advance directives.

http://www.breecollaborative.org/topic-areas/eol/

Definition: Advance Care Planning

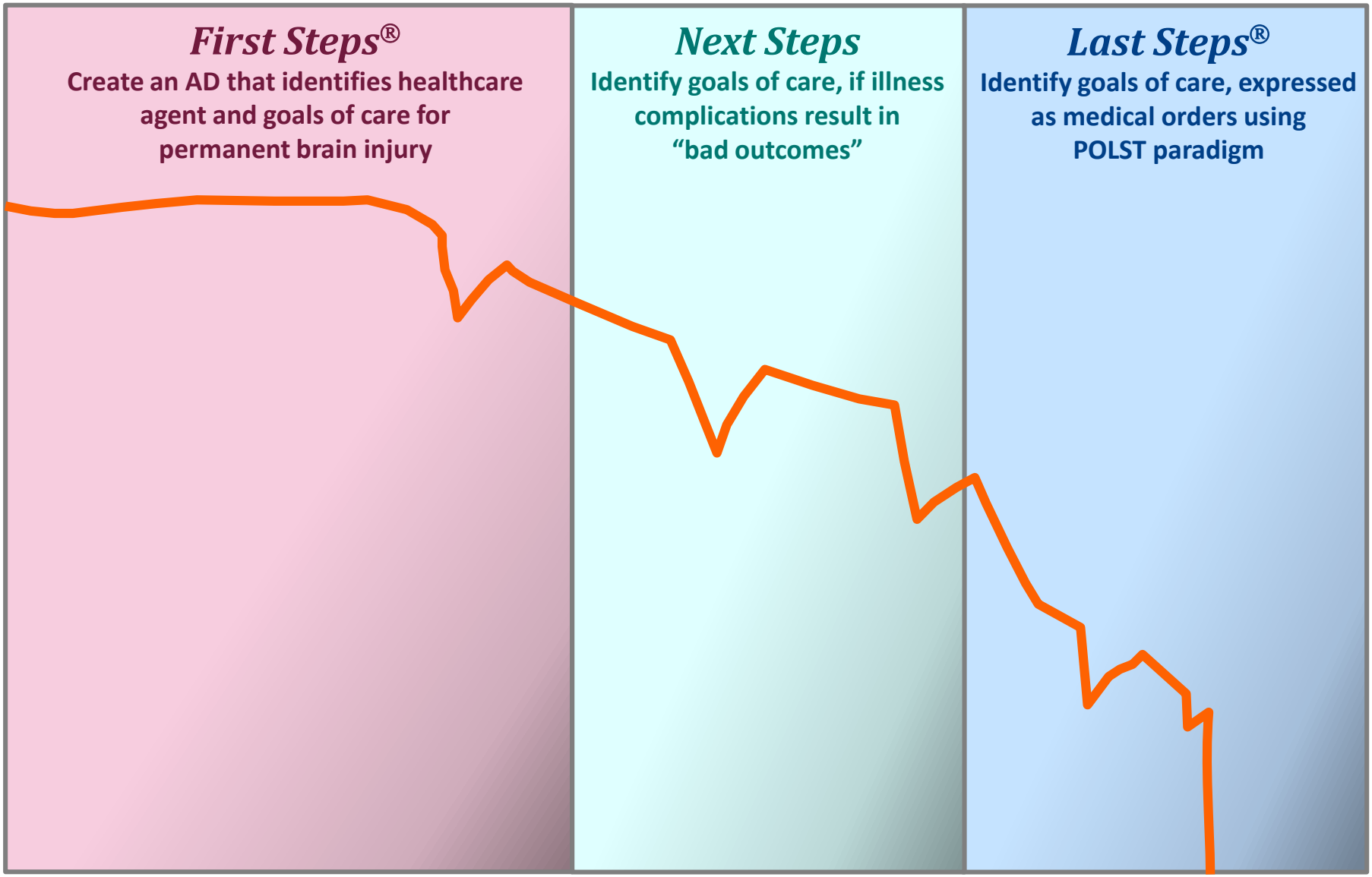
ACP is a *process* of communication for planning for future medical decisions. To be effective, this process includes

- **Reflection** on goals, values, and beliefs (including cultural, religious, spiritual, and personal)
- **Understanding** of possible future situations and decisions
- **Discussion** of these reflections and decisions with those who might need to carry out the plan

ADVANCE CARE PLANNING

- Is most effectively done in stages
- Does not attempt to plan for ALL possibilities in a single document, which is both impossible and unnecessary

Stages of Advance Care Planning Over an Individual's Lifetime



"Just Completing a Statutory AD Does Not Work"

The standard approach to advance directives (ADs) consistently fails to improve care

- The prevalence of ADs is low.
  - General population 20-30%
  - End-stage illness < 50%
- ADs are often unavailable at the place of treatment (available to the physician only 25% of time)
- ADs are often not helpful to decision making (i.e. too vague)
- ADs are often not followed
  - Unavailable or ambiguous
  - Not understood/supported by loved ones

(Agency for Healthcare Research and Quality, 2003)
(National Academy of Sciences, Institute of Medicine, 2014)
(Rand Corporation, 2007)
(Wilkinson, Wenger, Shugarman, 2007)

For ACP to Be Successful…

Plans must be

- Created — high prevalence is essential
- Specific enough for the clinical situation
- Accurately reflect the individual's preferences
- Understandable to those making decisions
- Available to the decision makers
- Incorporated into decisions, as needed

(Fagerlin & Schneider, 2004)

Being Mortal – Atul Gawande, MD

"People with serious illness have priorities besides simply prolonging their lives:

- Avoiding suffering
- Strengthening relationships with family and friends
- Being mentally aware
- Not being a burden on others
- Achieving a sense that their life is complete

"Our system of technological medical care has utterly failed to meet these needs and the cost of this failure is measured in far more than dollars. The question therefore is not how can we afford this system's expense, it is: **How can we build a health care system that will actually help people achieve what's most important to them at the end of their lives?**"

THE IMPORTANCE OF A SYSTEM

Key Elements in Sustaining an Effective ACP Program

1. **System Redesign**
   - ACP team and workflows
   - ACP document
   - Storage & retrieval
2. **ACP Education & Facilitator Certification**
   - ACP Facilitator training
   - ACP team education
   - Other stakeholder education
3. **Community Engagement**
   - Materials that engage
   - Strategies to engage
   - Special population groups
4. **Continuous Quality Improvement**
   - The Five Promises
   - Implementation project plan
   - Ongoing QI plan

(Hammes & Briggs, 2011)

Key Element #1: System Redesign

- Goal: To build an infrastructure that hardwires excellence
- Key infrastructure changes
  - Effective, standardized advance directive document (e.g., Power of Attorney for Healthcare)
  - Reliable medical record storage and retrieval, transfer of documents and ACP information
  - ACP team processes and workflows

Key Element #2:
Education & Facilitator Certification

- The role and responsibilities of the ACP Facilitator
- The role and responsibilities of other ACP team members
- Competency-based education

Goals for ACP Facilitation Skill-Building

- To provide a standardized curriculum for training members of the ACP team
- To ensure the delivery of a consistent and reliable ACP service
- To assist individuals with an informed, timely, and specific decision-making process
- To promote timely and appropriate referrals to other needed services

Key Element #3: Community Engagement

- Reach out to population with common, consistent, repetitive messages
  - Materials
  - Partnerships
  - Targeted education
- Develop strategies to meet the needs of special population groups

Key Element #4: Continuous Quality Improvement

If you don't measure it,

you can't improve it.

Five Promises of an Advance Care Planning System

PROMISE #1

We will initiate the conversation

PROMISE #2

We will provide assistance with advance care planning

PROMISE #3

We will make sure plans are clear

PROMISE #4

We will maintain and retrieve plans

PROMISE #5

We will appropriately follow plans

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Culture Change

- Start the conversation
  - Death isn't a taboo, but talking about how you want to die is
- Create systematic supports for change
  - Shift from a system of "completing an Advance Directive" to a system of person-centered advance care planning

WHAT IS THE EVIDENCE THAT SUCH A SYSTEM CAN BE SUCCESSFUL?

Outcomes of Sustained Approach

Increase in:

- Individual and family satisfaction
- Prevalence of planning
- Percentage of plans at time of death
- Number of hospice admissions

Reduction in:

- Family stress, anxiety, and depression
- Number of hospital deaths

Prevalence, Availability, and Consistency of Advance Directives in La Crosse County after the Creation of an ACP System in 1991-1993

	LADS I Data collected in '95/'96 N=540	LADS II Data collected in '07/'08 N=400	P value
Decedents with ADs (%)	459 (85.0)	360 (90.0)	.023
ADs found in the medical record where the person died (%)	437 (95.2)	358 (99.4)	<.001
Treatment decisions found consistent with instructions	98%	99.5%	0.13

(Hammes & Rooney, 1998)
(Hammes, Rooney, & Gundrum, 2010)

Australian ACP Study

- Setting: Tertiary hospital in Melbourne, Australia
- Participants: Competent, English-speaking patients 80 or older admitted to internal medicine, cardiology, or pulmonary services
  - Excluded if they were expected to die or discharged within 24 hours, had an AD, or did not have family
- Method: The intervention group received ACP developed from the La Crosse model (Respecting Choices) and the control patients received the local standard of care

(Detering, Hancock, Reade, & Silvester, 2010)

Patient Satisfaction Questionnaire*

Variable	Intervention Group (N= 133)	Control Group (N=139)	P Value
Overall level of satisfaction with hospital care			<0.001
Very satisfied	125 (93)	91 (65)	
Satisfied	6 (5)	40 (29)	
Not satisfied	2 (2)	8 (6)	

*Questionnaire administered at hospital discharge. Values are percentages, unless stated otherwise.

Study Outcomes When Subjects Died

	ACP	Control	P value
Deaths	29	27	
Wishes known and respected	25 (86%)	8 (30%)	<0.001
Family Stress	5	15	<0.001
Family Anxiety	0	3	0.02
Family Depression	0	5	0.002

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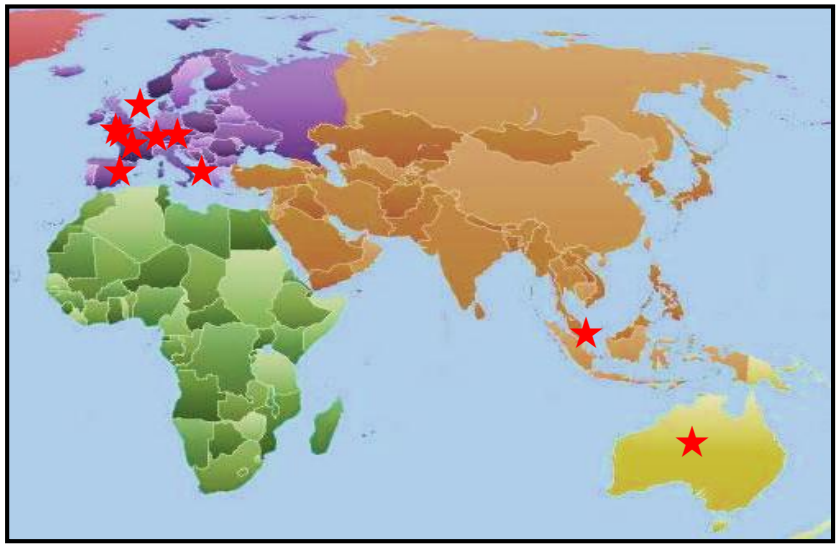
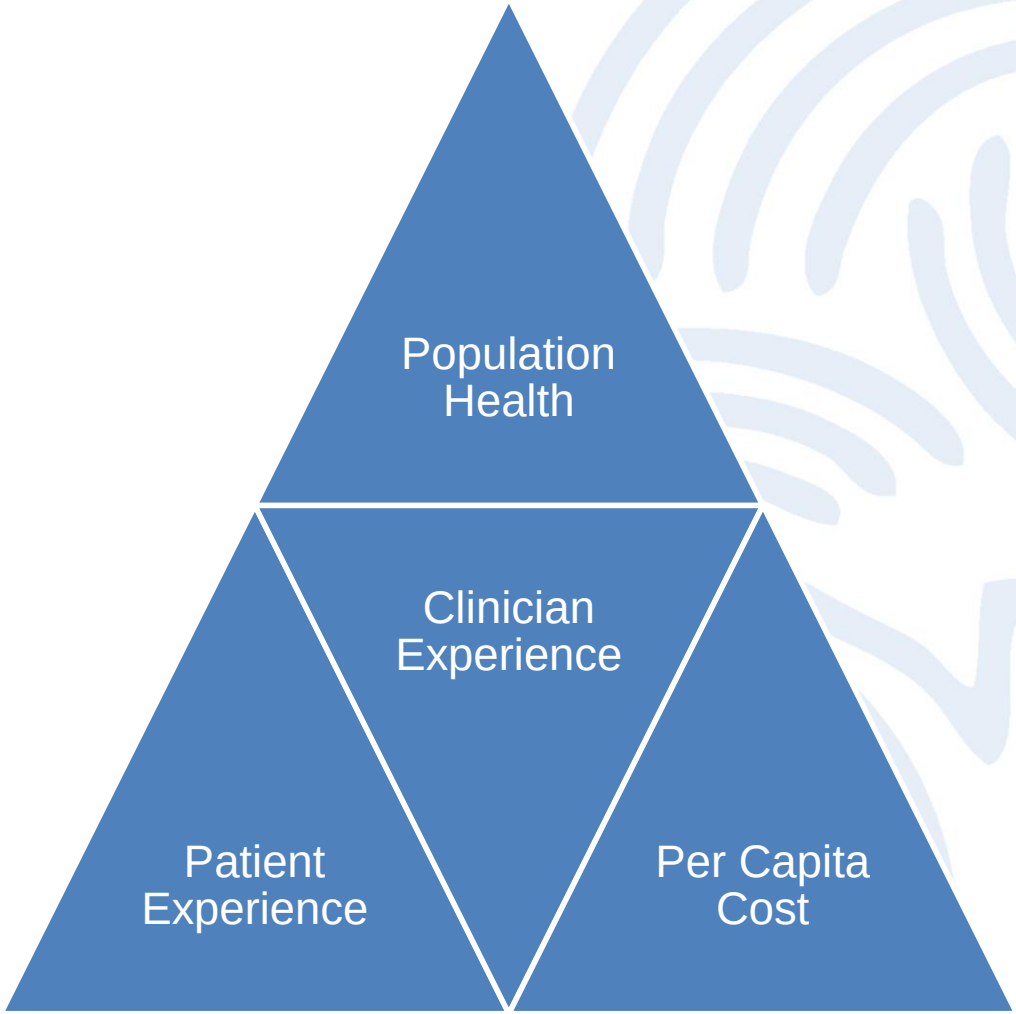
U.S.A.
Canada

Australia
Belgium
Denmark
Germany
Italy
Singapore
Slovenia
Spain
The Netherlands
United Kingdom



Quadruple Aim



Quadruple Aim

- Population Health/Better Outcomes:
  - Integrates ACP throughout the community
  - Increases hospice use at end of life
  - Promotes timely and appropriate referrals for other needed services (palliative care, care coordination)
  - Increases prevalence of planning in racially, ethnically, and culturally diverse communities

- Per Capita Cost:
  - In the last two years of life, the average cost of care in La Crosse is $48,000 compared to $80,000 nationally
  - The average number of inpatient days is 9.7 compared to 20.3 nationally

Quadruple Aim

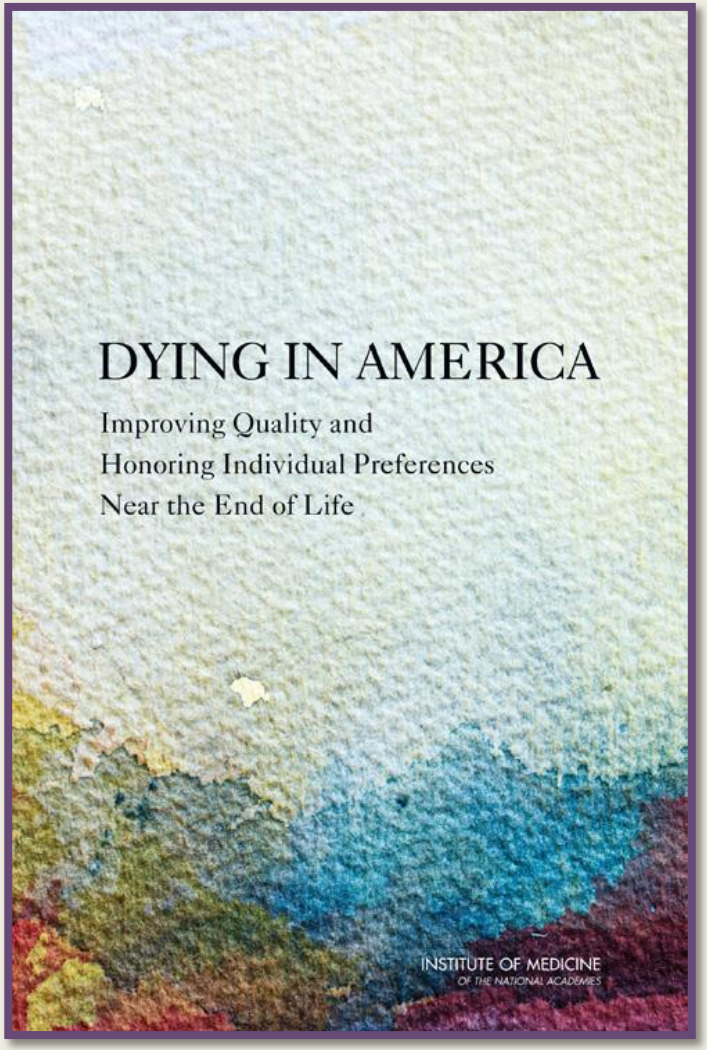
- Patient Experience:
  - Assists in providing care and treatment that is consistent with individual goals and values
  - Results in high individual and family satisfaction

- Clinician Experience:
  - Decreases moral distress of physicians and healthcare providers
  - Increases professional satisfaction with a standardized approach to ACP
  - Shifts time spent by physicians and healthcare teams on crisis end-of-life decision making to time spent on early and effective advance care planning

WHAT MAKES THE RESPECTING CHOICES ACP PROGRAM UNIQUE?

Respecting Choices is Comprehensive and Systematic

- **It works**
  - In all healthcare settings
  - For all aspects of care planning over an individual's lifetime
  - Toward community engagement
- **It provides**
  - Clearly defined roles and responsibilities of ACP team
  - Creation of work flows and processes
  - Redesign of EMR to support ACP workflows and facilitation



"One of the best-known advance directive initiatives is Respecting Choices"

(National Academy of Sciences, Institute of Medicine, 2014)

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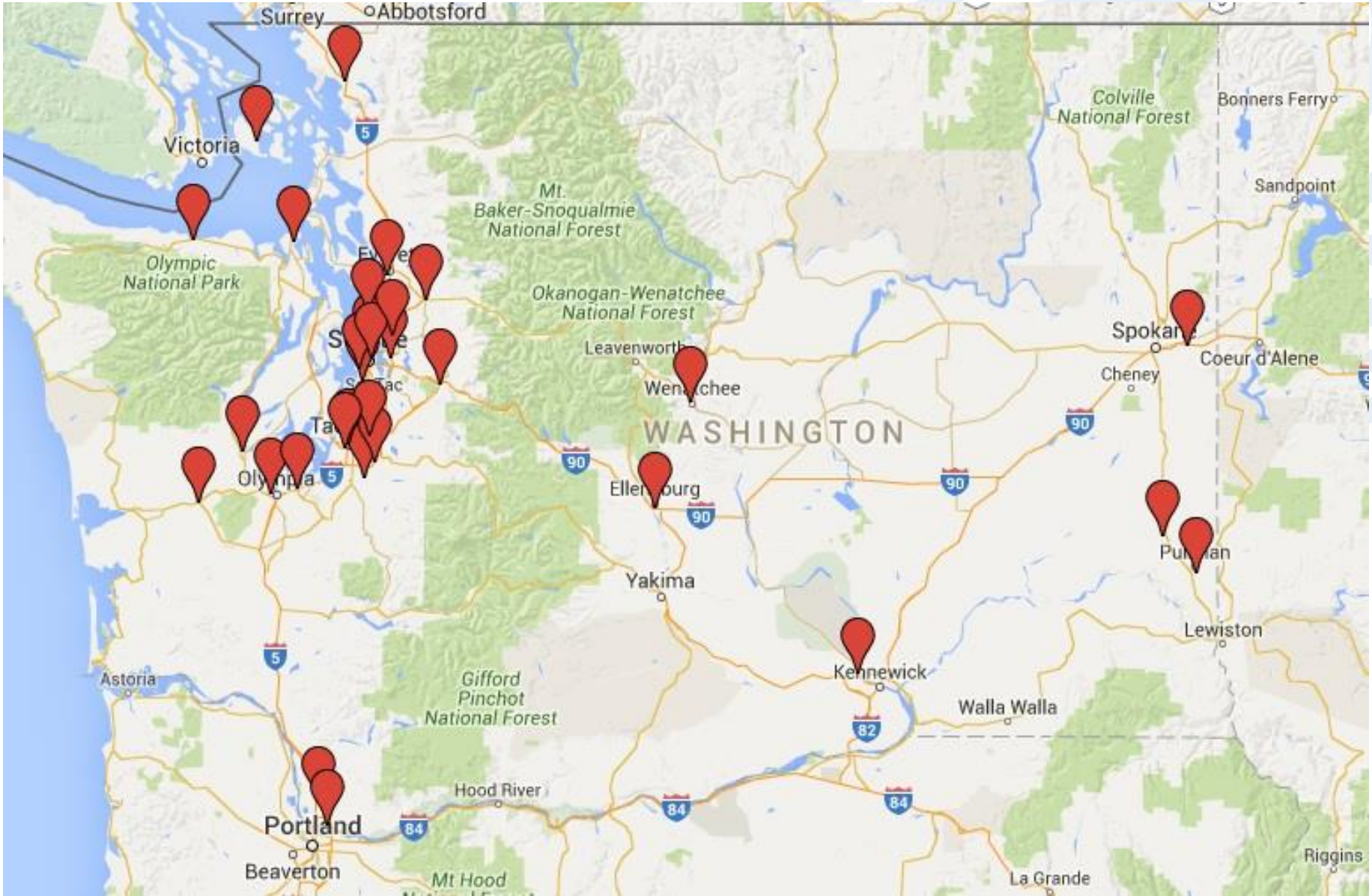
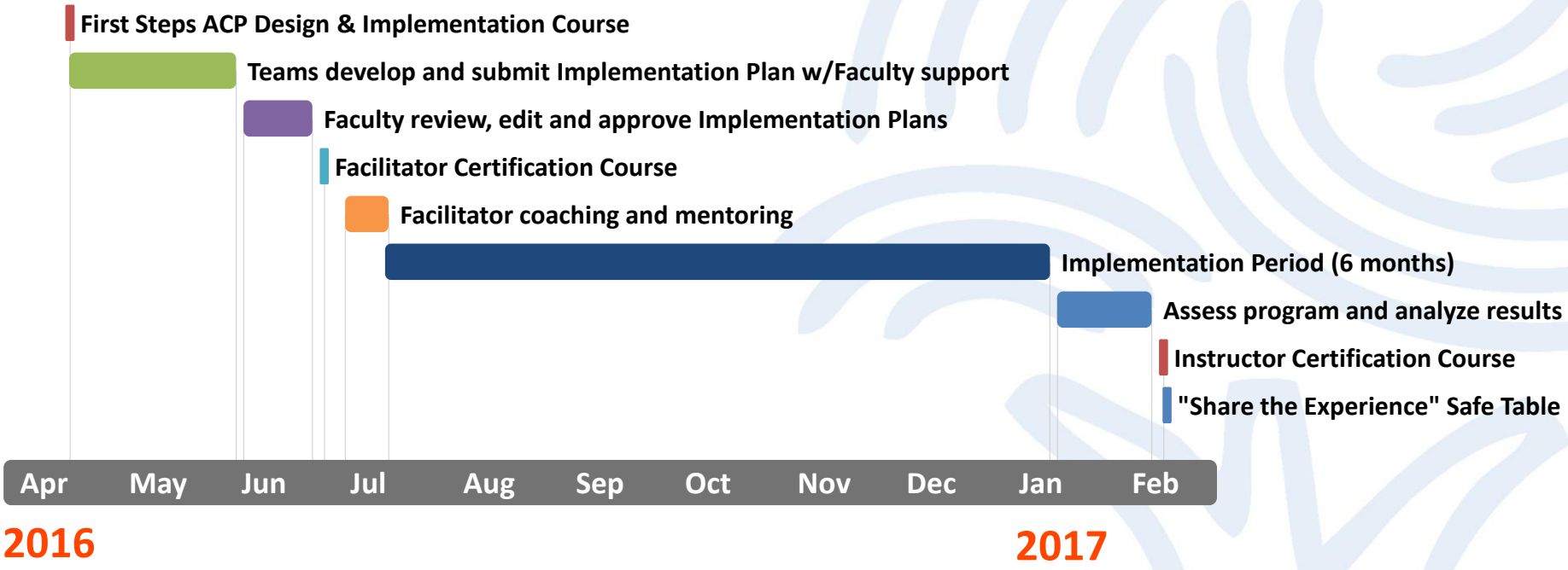
Launched October 23, 2015



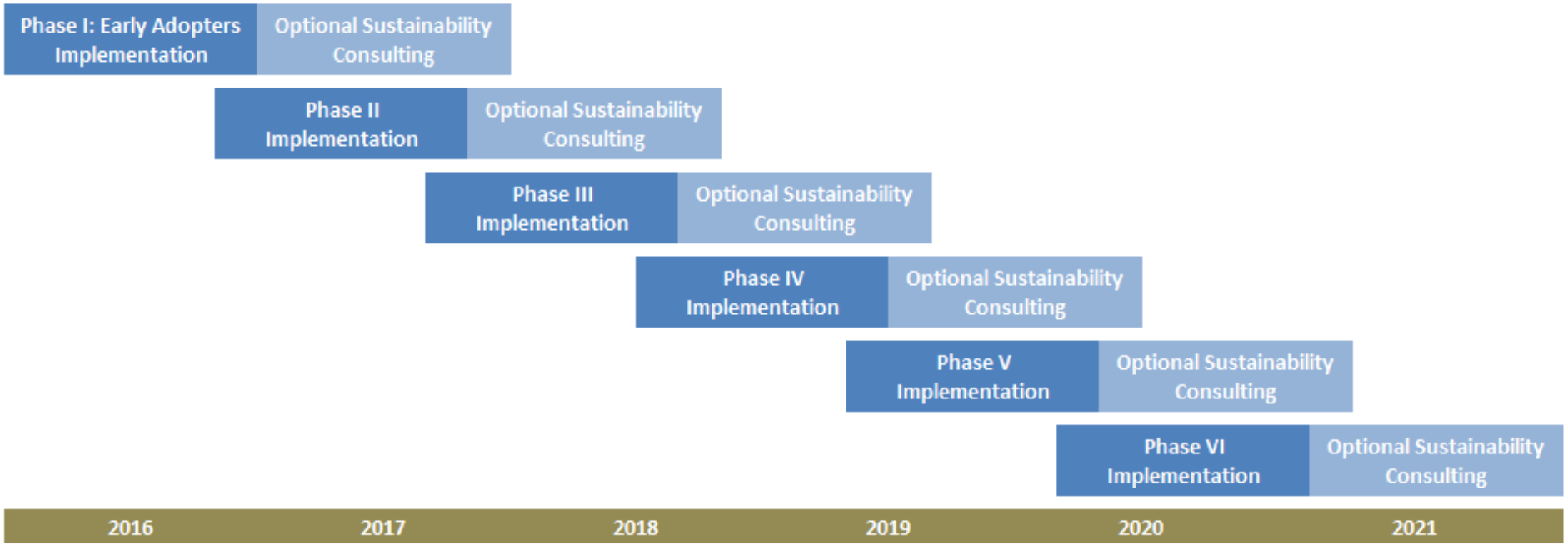
First Cohort

- Capital Medical Center
- CHI Franciscan Health
- **Confluence Health**
- EvergreenHealth
- Group Health Cooperative
- Jefferson Healthcare
- Kadlec Regional Medical Center
- Kittitas Valley Healthcare
- Mason General Hospital
- **MultiCare Health System**
- Olympic Medical Center
- Overlake Medical Center
- PeaceHealth
- **Providence Health & Services**
- **Pullman Regional Hospital**
- Snoqualmie Valley Hospital District
- Summit Pacific Medical Center
- Swedish Health Services
- The Everett Clinic
- **The Vancouver Clinic**
- UW Medicine Health System
- Virginia Mason Medical Center
- Whitman Hospital and Medical Center

Timeline for Implementation Teams



Statewide Implementation Timeline



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The Heart of Advance Care Planning

Rock Center Video:

http://www.nbcnews.com/video/rock-center/50112401#50112401

Thank you

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Carol Wagner
carolw@wsha.org

Jessica Martinson
jessica@wsma.org

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